KENTUCKY TEACHERS' RETIREMENT SYSTEM
Medicare Eligible Health Plan (MEHP)
ENROLLMENT FORM
479 Versailles Road, Frankfort, Kentucky 40601

****KTRS USE ONLY****
Insurance Effective Date
☐☐ / ☐☐ / ☐☐☐☐
Revised October 2006

REASON FOR APPLICATION:

☐ New Retiree ☐ Qualifying Event ☐ Open Enrollment

RETIREE INFORMATION (must be completed):

Retiree's Name	Social Security No.	Birthdate	Gender
_____	_____	_____	_____

RETIREE ENROLLMENT:

☐ I am Medicare eligible and desire to **enroll** in the KTRS MEHP administered by Humana and Medco.

I have _____ have not _____ enrolled in a Medicare Part D Prescription Drug Plan. **(Must check one)**

☐ I am **already** enrolled in the KTRS MEHP.

☐ I waive coverage through the KTRS MEHP.

SPOUSE ENROLLMENT:

☐ I wish to **enroll** my Medicare eligible spouse in the KTRS MEHP administered by Humana and Medco.

I have _____ have not _____ enrolled in a Medicare Part D Prescription Drug Plan. **(Must check one)**

Spouse's Name	Social Security No.	Birthdate	Gender
_____	_____	_____	_____

I understand that I am not eligible for the prescription portion of the KTRS Medicare Eligible Health Plan if I have enrolled in a Medicare Part D Prescription Drug Plan. I also understand that my coverage assumes Part B of Medicare and I have enrolled in Parts A and B of Medicare (if I am eligible).

RETIREE'S SIGNATURE: _____ **DATE:** _____

SPOUSE'S SIGNATURE
(If enrolling in coverage): _____ **DATE:** _____

Home address: _____
Street City State Zip Code

Home phone: _____

Email address: _____

REVERSE SIDE MUST BE COMPLETED

MEDICARE INFORMATION
(Copy information exactly from your Red, White & Blue Medicare Card)

Please write your Medicare number exactly as it appears on your Medicare Card. If you have applied for Medicare, but have not received your card you must contact your local Social Security office to request your Medicare number and effective dates of Parts B and/or A. Upon receiving your Medicare card, you must forward a copy to this office at the address given on the front of this form. Also, you must notify KTRS in the event your Medicare number changes due to the death of a spouse, marriage, or divorce.

RETIREE'S NAME: _____

SOCIAL SECURITY NUMBER:_____

MEDICARE CLAIM NUMBER: _____

HOSPITAL (PART A) EFFECTIVE DATE: _____

MEDICAL (PART B) EFFECTIVE DATE: _____

SPOUSE'S NAME: _____

SOCIAL SECURITY NUMBER:_____

MEDICARE CLAIM NUMBER: _____

HOSPITAL (PART A) EFFECTIVE DATE: _____

MEDICAL (PART B) EFFECTIVE DATE: _____

ATTACH A COPY OF THE APPLICANT'S MEDICARE CARD
or

FORWARD UPON RECEIPT
to:

Kentucky Teachers' Retirement System
479 Versailles Road
Frankfort KY 40601